Liability for Negligent Prenatal Diagnosis: Parents' Right to a "Perfect" Child?

I. INTRODUCTION

Advances in man's knowledge of human genetics, the ever-widening dissemination of the biomedical skills necessary for applying that knowledge, and a perceived desirability of putting those skills to use have combined to create a new[1] biomedical professional role—the genetic counselor.[2] In general, a genetic counselor is a person concerned with predicting and diagnosing the occurrence of genetic disorders and making evaluations that are helpful to his client. In this emerging era of planned parenthood, when couples seek to exercise control over many aspects of human reproduction, information concerning the genetic endowment of their children can have a momentous effect on the decision to procreate.[3] When a risk of genetic impairment or an undesirable gene-related characteristic is made known before conception or during pregnancy, a couple may choose to avert the birth of a child through contraception or eugenic abortion.[4]

As a developing area of clinical practice that has far-reaching consequences for the lives it touches, it was inevitable that genetic counseling would become a source of conflict requiring legal scrutiny. The most troubling problem to be raised in the courts is whether a medical practitioner may be liable if his conduct leads to the birth of a child afflicted with genetic disorder when the presence of that disorder might have been diagnosed through the use of prenatal diagnostic techniques. The New York Court of Appeals and the New Jersey Supreme Court recently became the first state courts of final jurisdiction to consider this question.[5] In *Becker v. Schwartz*,[6] the New York

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1. The term "genetic counseling" has a history dating back to the early 1900s, when this country witnessed its first popular eugenics movement, heralded by self-proclaimed social reformers. Sorenson, *From Social Movement to Clinical Medicine—The Role of Law and the Medical Profession in Regulating Applied Human Genetics* in GENETICS AND THE LAW 467, 471–77 (A. Milunsky & G. Annas eds. 1976). It is only in recent years, however, that medicine has shown receptivity to genetics and genetic counseling as a basis for prevention of disease. *Id.* at 475–76.

2. *See generally* Leonard, Chase & Childs, *Genetic Counseling: A Consumer's View*, 287 NEW ENGLAND J. MED. 433 (1972).

3. *See* Hall, *The Concerns of Doctors and Patients*, in ETHICAL ISSUES IN HUMAN GENETICS 23 (B. Hilton *et al.* eds. 1973).

4. *See* Roe v. Wade, 410 U.S. 113 (1973); Griswold v. Connecticut, 381 U.S. 479 (1965). Since techniques for artifically altering human genotypes ("genetic engineering") are still largely theoretical, prevention continues to be the emphasized medical approach to genetic disease. *See* P. REILLY, GENETICS AND SOCIAL POLICY 22–26 (1977).

5. Becker v. Schwartz, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978); Berman v. Allan, 80 N.J. 421, 404 A.2d 8 (1979). *See also* Gildiner v. Thomas Jefferson Univ. Hosp., 451 F. Supp. 692 (E.D. Pa. 1978)(child born with Tay-Sachs disease after parents were allegedly told that amniocentesis was negative); Park v. Chessin, 88 Misc. 2d 222, 387 N.Y.S.2d 204 (Sup. Ct. 1976), *modified*, 60 A.D.2d 80, 400 N.Y.S.2d 110 (1977), *modified sub nom.* Becker v. Schwartz, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978) (child born with polycystic kidney disease after physician allegedly assured the parents that disease was not hereditary); Greenberg v. Kliot, 47 A.D.2d 765, 367 N.Y.S.2d 966 (1975) (*mem.*) (child with impairments born after failure to offer amniocentesis).

6. 46 N.Y..2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978).

court permitted parents to recover the expenses of caring for a child born with a genetic impairment, but held that emotional distress caused by the birth was not compensable. Conversely, the New Jersey court in *Berman v. Allan*[7] permitted parents of a genetically impaired child to sue for damages for emotional distress, but denied recovery for any expenses related to raising the child. Both courts refused to recognize claims brought on behalf of the child for "wrongful life."

Public comment on these decisions has ranged from acclaim[8] to consternation.[9] One court has expressed the opinion that recognition of this new tort will impose an absolute duty upon obstetricians to provide comprehensive genetic services—in effect, compelling them to assume the role of genetic counselor by operation of law.[10] While that may be an overstatement, there is reason for concern among medical practitioners. One almost certain result of this new potential liability is that many practitioners will be forced to incorporate into their everyday practice a body of biomedical skills with which they are unfamiliar, and which some may feel is foreign to the proper goals of medicine.

To the extent *Becker* and *Berman* recognize that parents have a right to determine the biological characteristics of their offspring, or (from a slightly different perspective) to avoid the hardships involved in raising an abnormal child, the decisions also raise serious questions of social policy. The law of negligence functions as a means of social engineering.[11] From this perspective, it is important to consider the directions that the law takes, not only in relation to the technical and theoretical constructions familiar to students of law,[12] but also in relation to the social values by which all law must ultimately be judged.

This Comment examines the *Becker* and *Berman* cases in light of the historical development of genetic counseling and previous cases involving claims for wrongful birth and wrongful life. With the goal of suggesting just and workable limitations on liability, the Comment then explores two important aspects of the new cause of action recognized by the New York and New Jersey courts: the standard of care imposed upon a physician or other professional who is in a position to provide prenatal diagnostic services, and the issue of damages as it relates to the parents' claims. Finally, the Comment presents the writer's reservations concerning the judicial recognition of this cause of action. In view of the far-reaching effects upon health care that imposition of liability will produce, the patently subjective valuations of "defective" human life that lie unexpressed at the heart of these decisions,

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7. 80 N.J. 421, 404 A.2d 8 (1979).

8. Lavine, *Wrongful Birth Decision Termed Victory for Patients*, NAT'L L.J., Jan. 8, 1979, at 3, col. 1.

9. *Doctors Held Liable in Abnormal Births*, N.Y. Times, Dec. 28, 1978, § B, at 6, col. 4 (suggesting that some physicians will give up their obstetrics practice as a result of the *Becker* decision).

10. Howard v. Lecher, 53 A.D.2d 420, 424, 386 N.Y.S.2d 460, 462 (1976).

11. Pound, *Theory of Social Interests*, 15 PUB. AM. SOC. SOCIETY 16 (1920).

12. *See, e.g.*, Note, *Wrongful Life: A Modern Claim Which Conforms to the Traditional Tort Framework*, 20 WM. & MARY L. REV. 125 (1979).

and the sensitive questions of public policy involved, the Comment urges that recognition of this tort should be left to legislative bodies.

II. BACKGROUND

A. *The Expanding Role of Genetics in Medical Practice*

Until very recently, prenatal diagnosis and genetic counseling were scarce commodities in the market of biomedical services offered to the public. While large-scale genetic screening programs for the detection of a few treatable genetic disorders were being developed in the early 1960s,[13] individualized genetic services were still offered by only a small number of specialists affiliated with large university research centers and medical schools.[14]

Traditionally, prospective parents concerned with the possible occurrence of a hereditary disorder have actively sought advice in two situations. The most common is when a couple have previously given birth to a child with a congenital anomaly and want to know the chances of recurrence. The second situation arises when a couple are considering marriage or pregnancy for the first time and are aware that one or both of them may be carriers of a deleterious genetic trait because of some prior manifestation of a disorder, perhaps among blood relatives.[15] Until about a decade ago, methods of detecting and predicting the occurrence of such traits were often inexact.[16]

Today, new developments in genetic knowledge and technology have created the potential for more comprehensive application of genetics in the clinical setting. With information gained through analysis of accumulated statistical data, the frequency of genetic disorders can often be correlated

13. The first large scale screening efforts came in response to the development of a test to detect phenylketonuria (PKU), a metabolic disorder causing mental retardation that can be controlled by restricting the infant's diet. Almost all states today have mandatory PKU screening laws for newborns. Reilly, *State-Supported Mass Genetic Screening Programs*, in GENETICS AND THE LAW 159, 159–60 (A. Milunsky & G. Annas eds. 1976).

14. Sorenson, *Sociological and Psychological Factors in Applied Human Genetics*, in ETHICAL ISSUES IN HUMAN GENETICS 283, 290–93 (B. Hilton *et al.* eds. 1973).

15. *Id.* at 287–90.

16. The sum of every person's physical characteristics (phenotype) is determined in part by his unique genetic makeup (genotype). Thousands of deleterious genetic disorders have been catalogued. Transmission of genetic traits can be most easily predicted for single-gene (Mendelian) traits which exhibit simple patterns of inheritance (*e.g.*, hemophilia, sickle-cell anemia, and Tay-Sachs disease). Sometimes, a single-gene defect may arise by mutation spontaneously in the parents gamete cells (sperm and ova). Accurate prediction of the transmission of such genes may be very difficult. Erbe, *Mass Screening and Genetic Counseling in Mendelian Disorders*, in ETHICAL, SOCIAL AND LEGAL DIMENSIONS OF SCREENING FOR HUMAN GENETIC DISEASE 85 (D. Bergsma ed. 1974).

Polygenic (multifactorial) disorders are caused by the interaction of two or more genes (*e.g.*, diabetes mellitus, anencephaly, spina bifida). Prediction of the transmission of polygenic disorders is often inexact. Ehrman & Lappé, *Screening for Polygenic Disorders*, in ETHICAL, SOCIAL AND LEGAL DIMENSIONS OF SCREENING FOR HUMAN GENETIC DISEASE 101 (D. Bergsma ed. 1974).

Some disorders result from gross chromosomal anomalies or the presence of an extra chromosome. Certain disorders of this kind, such as Down's syndrome (mongolism), are known to occur more often with increased maternal age; among women between the ages of 40 and 45 years, the incidence of bearing a child with Down's syndrome is between 1 and 2 percent. C. STERN, PRINCIPLES OF HUMAN GENETICS 112 (3d ed. 1973); Carter, *Practical Aspects of Early Diagnosis*, in EARLY DIAGNOSIS OF HUMAN GENETIC DEFECTS 17, 19 (M. Harris ed. 1970).

with risk factors.[17] In addition, the growing arsenal of biochemical and cytogenetic screening tests have made it easier to discover carriers of certain unexpressed recessive genes. These capabilities make it possible in many instances to predict significant reproductive risks before any sign of genetic impairment has become apparent. Perhaps most important, however, has been the development of prenatal diagnostic techniques such as amniocentesis,[18] fetoscopy,[19] and ultrasonography,[20] which allow the detection of many genetic anomalies *in utero*.[21]

Genetic counseling, a field still in its infancy, notably lacks a system of professional norms commonly found in other disciplines. In the absence of licensure or certification requirements,[22] it may be practiced by physicians and nonmedically trained professionals alike.[23] Most formal genetic counseling takes place in regional centers employing a team approach,[24] which may bring a client together with an assortment of people with diversified training, including physicians, nurses, Ph.D's, and Masters level associates. Combined with the programs offered by many public health agencies,[25] these form a growing network of professional personnel devoted to advising women or couples about the risks of transmitting inheritable disorders, and detecting genetically impaired fetuses so that a woman carrying an affected fetus can abort.

The use of technology for prenatal diagnosis of genetic disorders has not, however, been welcomed universally by medical practitioners. Some physicians see the preventive medicine approach to genetic disease as a repudiation of the idea that the physician is the preserver of life. Thus, one physician has asked:

> When a child with Tay-Sachs disease is aborted, is that "therapy" for the aborted child? . . . The "new" emphasis on prevention of disease of genetic origin is on

17. *See* McKusick, *The Growth and Development of Human Genetics as a Clinical Discipline*, 27 AM. J. HUMAN GENETICS 261 (1975).

18. This procedure involves inserting a needle into the amniotic sac and withdrawing a sample of amniotic fluid; fetal cells contained in the fluid are then cultured so that further tests can be performed. A. MILUNSKY, THE PRENATAL DIAGNOSIS OF HEREDITARY DISORDERS 3–4 (1973).

19. Fetoscopy is a variation of the amniocentesis procedure, with the addition of an optical system to permit visualization of the fetus within the amniotic sac. It can also be used to take samples of the fetal blood, allowing detection of genetically related hemoglobinopathies such as sickle cell anemia. *See* Mahoney & Hobbins, *Fetoscopy and Fetal Biopsy*, in GENETICS COUNSELING 495 (H. Lubs & F. de la Cruz eds. 1977).

20. Ultrasound produces an image of the fetus which may be useful in determining the position and size of the fetus. Certain polygenic neural tube defects can be detected by this technique. Unlike amniocentesis and fetoscopy, ultrasonography appears to carry negligible risks of harming the fetus. *See* A. MILUNSKY, THE PRENATAL DIAGNOSIS OF HEREDITARY DISORDERS 137–38 (1973).

21. *Id.*

22. Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 622 (1979).

23. *Id.*; Sorenson, *From Social Movement to Clinical Medicine—The Role of Law and the Medical Profession in Regulating Applied Human Genetics*, in GENETICS AND THE LAW 467, 478 (A. Milunsky & G. Annas eds. 1976).

24. Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 621 n.12 (1979).

25. *See generally* Reilly, *State-Supported Mass Genetic Screening Programs*, in GENETICS AND THE LAW 159 (A. Milunsky & G. Annas eds. 1976).

> the prevention of the existence of persons who might have the potential for disease. To prevent disease in this context means preventing people.[26]

Even aside from the question whether abortion is an acceptable treatment for genetic disorders, practitioners may hesitate to employ or advise prenatal diagnosis when they believe that the risks accompanying the procedure outweigh the probable beneficial results. For example, the incidence of bearing a child with a chromosomal anomaly for women 35 to 39 years of age who are not otherwise known to be at special risk has been placed in one national study at approximately 1.5 percent.[27] At the same time, it is known that anmiocentesis carries a risk of causing spontaneous abortion that has been estimated to be from 1 to 2 percent.[28] The dilemma that this situation can produce for a physician is obvious. Does a woman's interest in avoiding the birth of a child with a chromosomal anomaly justify the use of amniocentesis in a case in which the chances of inadvertently killing a normal fetus are equal to or greater than the probability of detecting an affected one? Inherent in many genetic counseling situations is an unsettling conflict of interest between the fetus and its mother. To the extent that a physician's role has changed from protector of prenatal life to implementer of the woman's will, his legal duty toward the fetus has become blurred,[29] and perhaps irrelevant. Yet, the ethical implications of prenatal diagnosis may in many instances prove intolerable for a conscientious physician.

B. *A Brief History of Wrongful Birth and Wrongful Life*

A cause of action arising from the birth of a genetically impaired child requires consideration of certain issues also considered in suits brought by parents for the birth of a healthy but unwanted child. That type of suit commonly has been based on allegations that the defendant was negligent in performing a sterilization procedure,[30] dispensing oral contraceptives,[31] per-

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26. Murray, *The Practitioner's View of the Values Involved in Genetic Screening and Counseling*, in ETHICAL, SOCIAL AND LEGAL DIMENSIONS OF SCREENING FOR HUMAN GENETIC DISEASE 185, 193, 196 (D. Bergsma ed. 1974).

27. A. MILUNSKY, THE PRENATAL DIAGNOSIS OF HEREDITARY DISORDERS 24 (1973).

28. Medical Research Council Working Party on Amniocentesis, *An Assessment of the Hazards of Amniocentesis*, 85 BRIT. J. OBSTET. GYNAEC. 1, 3 (Supp. 2 1978). *See also* Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 671 n.222 (1979). In addition to possible damage to the fetus, which may include amnionitis, abruptio placenta, hemorrhage, and puncture of the fetus, amniocentesis carries small risks to the mother, including possible peritonitis, hemorrhage, perforation of the viscera, and Rh immunization with consequences for future pregnancies. A. MILUNSKY, THE PRENATAL DIAGNOSIS OF HEREDITARY DISORDERS 5–6 (1973).

29. *See generally* Green, *The Fetus and the Law*, in GENETICS AND THE LAW 19, 22 (A. Milunsky & G. Annas eds. 1976).

30. *E.g.*, Custodio v. Bauer, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967); Jackson v. Anderson, 230 So. 2d 503 (Fla. App. 1970); Sherlock v. Stillwater Clinic, 260 N.W.2d 169 (Minn. 1977); Christensen v. Thornby, 192 Minn. 123, 255 N.W. 620 (1934); Betancourt v. Gaylor, 136 N.J. Super. 69, 344 A.2d 336 (Super. Ct. Law Div. 1975).

31. *E.g.*, Troppi v. Scarf, 31 Mich. App. 240, 187 N.W.2d 511 (1971).

forming an abortion,[32] or failing to diagnose pregnancy in time for a legal abortion to be procured,[33] with the resulting birth of a healthy child.[34] The courts have generally permitted recovery of medical costs and pain and suffering caused by the birth,[35] but have been divided on whether parents can recover the normal costs of raising the child.[36] Cases disallowing this recovery have reasoned that, as a matter of law, the birth of a healthy child confers intangible benefits upon the parents which outweigh the detriments of child-rearing.[37] This so-called "overriding benefits" doctrine as a matter of law, can be seen in the following passage:

> [T]he satisfaction, joy and companionship which normal parents have in rearing a child make such economic loss worthwhile. These intangible benefits, while impossible to value in dollars and cents are undoubtedly the things that make life worthwhile. Who can place a price tag on a child's smile or the parental pride in a child's achievement? . . . Rather than attempt to value these intangible benefits, our courts have simply determined that public sentiment recognizes that these benefits to the parents outweigh their economic loss in rearing and educating a healthy, normal child.[38]

The cases following this reasoning have met with disapproval by some commentators[39] for the reason that in today's society, the birth of an unwanted child should no longer in all instances be considered a net benefit. It is claimed that it is more realistic to allow the jury to consider the benefits conferred by the child as mitigating factors.

The 1960s witnessed the introduction of a new kind of negligence action involving a claim by a child that his birth occurred under conditions that burdened his existence. The first of these wrongful life cases, *Zapeda v. Zapeda*,[40] involved the claim of an illegitimate child against his own father, who had engaged in extra-marital sex with the plaintiff's mother after making promises of future matrimony. The Illinois appellate court found that plaintiff had indeed suffered a tortious injury, being burdened with the disadvantages of illegitimacy throughout his life. Nevertheless, the court denied recovery on the policy ground that recognition of such a cause of action would result in a

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32. *E.g.*, Stills v. Gratton, 55 Cal. App. 3d 698, 127 Cal. Rptr. 652 (1976); Ladies Center of Clearwater, Inc. v. Reno, 341 So. 2d 543 (Fla. Dist. Ct. App. 1977).

33. *E.g.*, Rieck v. Medical Protective Co., 64 Wis. 2d 514, 219 N.W.2d 242 (1974).

34. *Cf.* Bowman v. Davis, 48 Ohio St. 2d 41, 356 N.E.2d 469 (1976) (negligent sterilization resulting in birth of twins, one normal and one with deformities).

35. *E.g.*, Stills v. Gratton, 55 Cal. App. 3d 698, 127 Cal. Rptr. 652 (1976). *Contra*, Rieck v. Medical Protective Co., 64 Wis. 2d 514, 219 N.W.2d 242 (1974).

36. Recovery was denied in Coleman v. Garrison, 349 A.2d 8 (Del. 1975); Shaheen v. Knight, 11 Pa. D. & C.2d 41 (C.P. 1957); Terrel v. Garcia, 496 S.W.2d 124 (Tex. Civ. App. 1973), *cert. denied*, 415 U.S. 927 (1974); Ball v. Mudge, 64 Wash. 2d 247, 391 P.2d 201 (1964). Recovery was permitted in Custodio v. Bauer, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967); Troppi v. Scarf, 31 Mich. App. 240, 187 N.W.2d 511 (1971); Betancourt v. Gaylor, 136 N.J.Super. 69, 344 A.2d 336 (Super. Ct. Law Div. 1975).

37. *E.g.*, Terrel v. Garcia, 496 S.W.2d 124 (Tex. Civ. App. 1973), *cert. denied*, 415 U.S. 927 (1974).

38. *Id.* at 128.

39. Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 632–33 (1979); Robertson, *Civil Liability Arising from "Wrongful Birth" Following an Unsuccesful Sterilization Operation*, 4 AM. J. LAW & MED. 131, 151 (1978).

40. 41 Ill. App. 2d 240, 190 N.E.2d 849 (1963), *cert. denied*, 379 U.S. 945 (1964).

flood of cases ill-suited for adjudication: "One might seek damages for being born of a certain color, another because of race; one for being born with a hereditary disease, another for inheriting unfortunate family characteristics . . . ."[41]

Several cases have been brought within the past fifteen years involving infants suffering from birth defects. In *Gleitman v. Cosgrove*,[42] a decision of the New Jersey Supreme Court which that court was compelled to reconsider in *Berman v. Allan*,[43] damages were sought by both the impaired child and his parents, who contended that the defendant physicians had erroneously informed the mother that the rubella infection she contracted early in her pregnancy posed no risk to her child. The child was born with substantial physical impairments.[44] The court dismissed the claims of both the child and the parents. Concerning the child's claim, the court held the view that "life with defects" is preferable to no life at all;[45] weighing the value of life with impairments against the "utter void of nonexistence" was "logically impossible."[46] Therefore, according to the court, the child could not establish the necessary element of damages. Concerning the parents' claims, the majority said:

> In order to determine [the parents'] compensatory damages a court would have to evaluate the denial to them of the intangible, unmeasurable, and complex human benefits of motherhood and fatherhood and weigh these against the alleged emotional and money injuries. . . . When the parents say their child should not have been born, they make it impossible for a court to measure their damages in being the mother and father of a defective child.[47]

This reasoning is similar to the overriding benefits doctrine seen in the "healthy but unwanted" wrongful birth cases, except that instead of finding a net benefit, as a matter of law, the *Gleitman* court found that the injury was unascertainable as a matter of law. Moreover, the court held that, even assuming Mrs. Gleitman could have procured a legal abortion at that time, it would be against the public policy of New Jersey to allow her and her husband to recover for "the denial of the opportunity to take an embryonic life."[48]

Two courts considering similar suits in other jurisdictions several years after *Gleitman* were not persuaded by the reasoning of the New Jersey court. *Jacobs v. Theimer*[49] and *Dumer v. St. Michael's Hospital*[50] permitted parents of children suffering from rubella-related impairments to recover costs relating to the children's special care and treatment. Both the Supreme Court of

41. 41 Ill. App. 2d 240, 260, 190 N.E.2d 849, 858 (1963), *cert. denied*, 379 U.S. 945 (1964).
42. 49 N.J. 22, 227 A.2d 689 (1967).
43. 80 N.J. 421, 404 A.2d 8 (1979).
44. 49 N.J. 22, 24–25, 227 A.2d 689, 690 (1967).
45. 49 N.J. 22, 28, 227 A.2d 689, 692 (1967).
46. *Id.*
47. 49 N.J. 22, 29, 227 A.2d 689, 693 (1967).
48. *Id.* at 30, 227 A.2d at 693.
49. 519 S.W.2d 846 (Tex. 1975).
50. 69 Wis. 2d 766, 233 N.W.2d 372 (1975).

Texas and the Supreme Court of Wisconsin, however, followed *Gleitman* in dismissing the children's claims for wrongful life.

No court in any jurisdiction recognized a cause of action for wrongful life until 1977, when the New York Supreme Court's Appellate Division broke with all precedent in *Becker v. Schwartz*[51] and its companion case, *Park v. Chessin*.[52] In support of its recognition of a cause of action on behalf of a child born with a genetic defect, the court said:

> Inherent in the abolition of the statutory ban on abortion . . . is a public policy consideration which gives potential parents the right . . . not to have a child. This right extends to instances in which it can be determined with reasonable medical certainty that the child would be born deformed. The breach of this right may also be said to be tortious to the fundamental right of a child to be born as a whole, functional human being.[53]

Unfortunately, the court's analysis failed to explain the gap in the logical progression from the right of the parents not to have a child to the conclusion that a breach of the parents' right may also constitute a wrong vis-à-vis the fundamental right of the child. Neither did the court explain the source of this new right to be born a whole, functional human being. These weaknesses led most commentators to conclude that the Appellate Division's holding would either have to be bolstered with a better theoretical foundation, or be abandoned.[54]

It was at this point in the judicial development of wrongful birth and wrongful life that *Becker v. Schwartz* and *Berman v. Allan* came to be heard by the high courts of New York and New Jersey.

III. FACTS AND HOLDINGS

Becker v. Schwartz[55] considered the consolidated appeals of two cases from the New York Supreme Court, Appellate Division.[56] In the first case, Dolores Becker, 37 years of age, conceived a child in the fall of 1974. She engaged the services of the defendants, specialists in the field of obstetrics

51. 60 A.D.2d 587, 400 N.Y.S.2d 119 (1977), *modified*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978).

52. 60 A.D.2d 80, 400 N.Y.S.2d 110 (1977), *modified*, 46 N.Y.2d 401, 386 N.E.2d 807 413 N.Y.S.2d 895 (1978).

53. *Id.* at 88, 400 N.Y.S.2d at 114.

54. *See, e.g.*, Cohen, Park v. Chessin: *The Continuing Judicial Development of the Theory of "Wrongful Life,"* 4 AM. J. LAW & MED. 212, 214 (1978); Robertson, *Toward Rational Boundaries of Tort Liability for Injury to the Unborn: Prenatal Injuries, Preconception Injuries and Wrongful Life*, 1978 DUKE L.J. 1401, 1443–44. *But see* Curlender v. Bio-Science Labs, 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980) (recognizing infant's wrongful life cause of action against laboratory for failing to diagnose Tay-Sachs disease). The *Curlender* opinion is remarkable as an example of judicial facility in solving difficult analytical problems by side-step.

55. 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978).

56. Becker v. Schwartz, 60 A.D.2d 587, 400 N.Y.S.2d 119 (1977), *modified*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978); Park v. Chessin, 60 A.D.2d 80, 400 N.Y.S.2d 110 (1977), *modified*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1975). The *Park* case involved allegedly negligent pre-conception genetic counseling, not prenatal diagnosis, and falls outside the scope of this Comment. Many of the issues in claims for preconception torts are identical, however, to claims for negligent prenatal diagnosis.

and gynecology, who cared for her throughout her pregnancy. In 1975, Mrs. Becker gave birth to an infant who suffered from Down's syndrome. Mr. and Mrs. Becker contended that defendants never advised them of the risk of giving birth to a child with Down's syndrome, which risk increases with maternal age, or of the availability of amniocentesis to determine whether the fetus was affected with the chromosomal anomaly causing that disorder. The Beckers claimed that, had they known their child would be born with the genetic impairment, they would have aborted the child. The Beckers commenced an action seeking damages on behalf of the child for wrongful life, and on their own behalf for the expenses of long-term care of the child, emotional and physical injury suffered as a result of the birth, and loss of Mrs. Becker's services.[57]

Upon motion by the defendants, the trial court dismissed the plaintiffs' complaint in its entirety for failing to state a cause of action.[58] The Appellate Division modified the order on appeal, sustaining the plaintiffs' complaint except for the parents' claims for emotional distress.[59]

Analyzing the claims under traditional medical malpractice theory, the New York Court of Appeals found two flaws in the infant's claim for wrongful life. First, the court found that the infant had not suffered any legally cognizable injury. While the Appellate Division had envisioned a basis for the infant's claim in a "fundamental right of a child to be born as a whole, functional human being," the Court of Appeals tersely dismissed this idea:

> [T]here is no precedent for recognition [of such a right]. . . . Not only is there to be found no predicate at common law or in statutory enactment for judicial recognition of the birth of a defective child as an injury to the child; the implications of any such proposition are staggering.[60]

A second flaw found by the court was the impossibility of measuring damages. Since the remedy afforded by law is a measure of damages calculated to put the plaintiff in the position that he would have been in but for the negligence of the defendant, such a measure here would require "a comparison between the Hobson's choice of life in an impaired state and nonexistence. This comparison the law is not equipped to make."[61]

The claim of the parents, however, stood on a different footing: "Plaintiffs state causes of action in their own right predicated upon a breach of a duty flowing from defendants to themselves, as prospective parents, resulting in damage to plaintiffs for which compensation may be readily fixed."[62] Citing its earlier decision in *Howard v. Lecher*,[63] the court went on to limit the

57. 46 N.Y.2d 401, 405–06, 386 N.E.2d 807, 808–09, 413 N.Y.S.2d 895, 896–97 (1978).
58. 46 N.Y.2d 401, 406, 386 N.E.2d 807, 809, 413 N.Y.S.2d 895, 897 (1978).
59. 60 A.D.2d 587, 588, 400 N.Y.S.2d 119, 120 (1977).
60. 46 N.Y.2d 401, 411, 386 N.E.2d 807, 812, 413 N.Y.S.2d 895, 900 (1978).
61. *Id.* at 412, 386 N.E.2d at 812, 413 N.Y.S.2d at 900.
62. *Id.* at 413, 386 N.E.2d at 813, 413 N.Y.S.2d at 901.
63. 42 N.Y.2d 109, 366 N.E.2d 64, 397 N.Y.S.2d 363 (1977). In *Howard v. Lecher*, parents sought damages for emotional injury for the birth of a child with Tay-Sach's disease. The Court of Appeals, in a 4–3 decision, dismissed the action on the ground that the parents were in the position of bystanders who witnessed the

parents' compensation by denying recovery for psychic or emotional distress caused by the birth of the child in an impaired state. The court noted that the parents might yet experience love and affection for the child,[64] and that to assess damages for emotional harm would require consideration of this factor in mitigation of the parents' emotional injuries. "[Such a] calculation of plaintiffs' emotional injuries remains too speculative to permit recovery . . . ."[65]

In a dissenting opinion,[66] two of the judges would have dismissed the plaintiffs' complaint *in toto*. In the dissenters' view, the Beckers' claims could be valid only if seen as derivative to the child's claim, since it was the child who suffered the physical impairment. The child had no valid claim either; the defendants' conduct in no way caused the child's injury, which was genetically determined. The majority "has created a kind of medical paternity suit. It is a tort without precedent, and at variance with existing precedents both old and new. . . . [T]hese cases pose a problem which can only be properly resolved by a legislative body, and not by courts of law."[67]

Berman v. Allan[68] presented the courts of New Jersey with factual allegations almost identical to those considered by the New York court in *Becker*. Like Mrs. Becker, Mrs. Berman sought medical care from two practicing obstetricians when she became pregnant in 1974. She was 38 years old at the time. She alleged that her physicians failed to inform her during the pregnancy of the availability of amniocentesis, or of the increased risk for women of her age of bearing a child afflicted with Down's syndrome. In addition, she alleged that if the defendants had so informed her, she would have submitted to amniocentesis, discovered that the fetus was afflicted, and had the fetus aborted. Instead, Mrs. Berman gave birth to Sharon, who exhibited Down's syndrome.[69]

Sharon, by her guardian *ad litem*, sought compensation for the physical and emotional pain that she would endure throughout her life because of her condition. Mr. and Mrs. Berman sought damages for the emotional anguish that they had experienced and would continue to experience because of

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physical injuries of their child. Like most jurisdictions, New York follows the "zone of danger" rule, which denies recovery for emotional injury unless the plaintiff was in physical peril from the same negligent conduct as a third person who was physically injured. *See* Tobin v. Grossman, 24 N.Y.2d 609, 249 N.E.2d 419, 301 N.Y.S.2d 554 (1969). The application of this rule to wrongful birth cases has rightly been critized as inappropriate, considering that the parents in wrongful birth cases allege the breach of a duty owed directly to them, and not that the defendant "caused" the child's defect. *See* Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 640–41 (1979). In *Becker*, the majority concurred in the result of *Howard*, but no longer subscribed to the reasoning of that case.

64. The court's speculation on this point was probably inaccurate concerning the Beckers. While they were pursuing their claim for "long-term institutional care" of their child in the courts, the Beckers had placed their daughter up for adoption. N.Y. Times, Feb. 17, 1979, at 23, col. 1.

65. 46 N.Y.2d 401, 415, 386 N.E.2d 807, 814, 413 N.Y.S.2d 895, 902 (1978).

66. *Id.* at 417–22, 386 N.E.2d at 816–19, 413 N.Y.S.2d at 904–07.

67. *Id.* at 422, 386 N.E.2d at 819, 413 N.Y.S.2d at 907.

68. 80 N.J. 421, 404 A.2d 8 (1979).

69. *Id.* at 423–24, 404 A.2d at 10.

Sharon's condition, and expenses that they would incur in raising, educating, and supervising Sharon.[70]

The trial court granted summary judgment in favor of defendants. Relying on *Gleitman v. Cosgrove*,[71] the trial judge ruled that plaintiffs had failed to state a cause of action. While an appeal of that ruling was pending before the court of appeals, the New Jersey Supreme Court certified the case for review on its own motion.[72]

Accepting as true each of the plaintiffs' allegations, the court considered the sufficiency of the child's and the parents' claims separately. The child's claim, said the majority, could not stand:

> [A] claim predicated upon wrongful life . . . would require the trier of fact to measure the difference in value between life in an impaired condition and the "utter void of nonexistence." Such an endeavor . . . is literally impossible . . . .
>
> Difficulty in the *measure* of damages is not, however, our sole concern. . . . [W]e conclude . . . that Sharon has not suffered any damage cognizable at law by being brought into existence. *See, e.g., Becker v. Schwartz* . . . .[73]

Concerning the parents' claims, the court reconsidered its earlier decision in *Gleitman v. Cosgrove*,[74] a 1967 case which held that parents of a deformed child could not recover from a physician who had failed to warn the mother of the risks to her child from rubella. The *Gleitman* majority had concluded that substantial public policy reasons precluded the allowance of tort damages to the parents for the denial of the opportunity to abort their child.[75] The *Berman* majority now believed that the Supreme Court ruling in *Roe v. Wade*[76] reversed New Jersey's public policy on abortion. "Public policy now supports, rather than militates against, the proposition that [a woman] not be impermissibly denied a meaningful opportunity to make that decision. . . . [A] physician whose negligence has deprived a mother of this opportunity should be required to make amends for the damage which he has proximately caused."[77]

Oddly, the New Jersey Supreme Court then took away what it had just seemed ready to give, by refusing to allow the Bermans to recover for any pecuniary damages arising from Sharon's birth. The court said that "such an award would be wholly disproportionate to the culpability involved [and] would both constitute a windfall to the parents and place too unreasonable a financial burden upon physicians."[78] Instead, the majority believed that an

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70. *Id.* at 425, 404 A.2d at 10–11.
71. 49 N.J. 22, 227 A.2d 689 (1967). *See* text accompanying notes 42–48 *supra*.
72. 80 N.J. 421, 425, 404 A.2d 8, 11 (1979).
73. *Id.* at 428–29, 404 A.2d at 12 (emphasis in original) (citations omitted).
74. 49, N.J. 22, 227 A.2d 689 (1967).
75. *Id.* at 30, 227 A.2d at 693.
76. 410 U.S. 113 (1973).
77. 80 N.J. 421, 432, 404 A.2d 8, 14 (1979).
78. *Id.* at 432, 404 A.2d at 14.

appropriate basis for recovery was the parents' emotional distress "deriving from Mrs. Berman's loss of her right to abort the fetus."[79]

In a rambling dissent,[80] Judge Handler said he would allow the child's claim for wrongful life, based upon the injury of "diminished childhood." In his view, Sharon had been damaged by being born to parents who were "less fit to accept and assume their parental responsibilities,"[81] a condition which Handler believed was directly attributable to the defendants' negligence.

IV. Toward Rational Limits On Liability

Both the New York Court of Appeals and the New Jersey Supreme Court envisaged the claims before them in *Becker*[82] and *Berman*[83] as falling within the traditional framework of medical malpractice. As such, the parents' cause of action for wrongful birth is analyzed according to the familiar formula of duty, breach, proximate cause, and cognizable damages.[84]

In the absence of a warranty, a medical practitioner is not considered to guarantee the results of his care.[85] Thus, a medical practitioner acting in the role of genetic counselor can be held liable for the birth of a "less-than-perfect" child only if the birth of that child was caused by the practitioner's negligence. The practitioner is not an insurer of the genetic well-being of each newborn.

At the same time, a woman's ability to choose whether to give birth to a child with a genetic impairment is directly dependent upon information that is generally available only from professionals. Her "right" to give birth to a child that comports with her hopes is limited (1) to the extent that medical knowledge remains incomplete and (2) by the amount of information and diagnostic service that is made available to her. The law of tort has little effect on the former, but undoubtedly can influence the latter by establishing and defining the medical practitioner's legal duty. This is particularly true in an area of professional practice like genetic counseling, which has not yet developed its own comprehensive standards.[86]

Becker and *Berman* have decided, for their respective jurisdictions, that the parents' "injury" of bearing a "defective" child, caused by the negligence of another, is a compensable harm; hence, the interest of a couple in avoiding the birth of a "defective" child is now to be afforded the protection of the law.

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79. *Id.* at 433, 404 A.2d at 14.

80. *Id.* at 434–46, 404 A.2d at 15–21.

81. *Id.* at 442, 404 A.2d at 19.

82. 46 N.Y.2d 401, 410, 386 N.E.2d 807, 811, 413 N.Y.S.2d 895, 899 (1978).

83. 80 N.J. 421, 434, 404 A.2d 8, 15 (1979) (Handler, J., concurring in part and dissenting in part).

84. *See* W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 30 at 143 (4th ed. 1971).

85. *See, e.g.*, Bishop v. Byrne, 265 F. Supp. 460 (S.D.W.Va. 1967); Lane v. Cohen, 201 So. 2d 805 (Fla. Dist. Ct. App. 1967). A few courts have permitted a claim for medical malpractice based on a contract theory of implied promise to exercise reasonable skill. *See, e.g.*, Baldwin v. Saunders, 266 C.S. 394, 223 S.E.2d 602 (1975). In most jurisdictions, however, such claims must be brought in tort. *See* Note, *Establishing the Contractual Liability of Physicians*, 7. U. CAL. DAV. L. REV. 84 (1974).

86. *See* text accompanying notes 22–25 *supra*. and notes 91–93 *infra*.

It will be left to future cases, however, to determine precisely where the outer bounds of that protection lie. The most important bound-setting element in the theory of liability is the standard of care.

A. *The Standard of Care*

As in any negligence action, parents seeking to recover damages for the birth of a "defective" child must prove at trial that the defendant in some way failed to perform in accordance with the standard of care established by law. The conduct complained of may have been either nonfeasance or misfeasance—that is, an act of omission or an act of commission. A practitioner may have failed to disclose information that the plaintiff claims would have led her to avoid the birth, or he may have conveyed inaccurate information, reliance upon which led the plaintiff to make a wrong decision. Since, in either case, the disclosure of information has meaning only in relation to the plaintiff's decision-making ability, the relevant question is whether the defendant practitioner failed to give the plaintiff legally adequate information to afford her a "meaningful opportunity to make the decision."[87]

This question of legal adequacy, which is merely a more precise way of asking whether the defendant breached the standard of care, can clearly be seen to involve two different aspects of the defendant's conduct. The first of these aspects comprehends the level of expert knowledge and skill that the defendant is expected to exercise in the scope of his practice. For the purposes of this discussion this aspect will be termed the "knowledge aspect." Functions of this aspect include the defendant's ability to recognize the existence of certain genetic risks and the appropriateness of using diagnostic tools, the skill required to interpret test results accurately, and the ability to perceive the need to refer a client to a specialist. The second aspect, on the other hand, encompasses the act of communicating information to a client. The legal adequacy of this communication may depend not only on *whether* information is disclosed, but also on the *extent* of the information disclosed and the *manner* in which it is conveyed. This aspect will be termed the "communication aspect."

There are two distinct approaches that by analogy can be used to set the standard of care owed by a medical practitioner acting in the role of genetic counselor. Under the traditional professional standard applied in other medical malpractice cases, a defendant's allegedly negligent conduct is measured against the established norms of the defendant's professional peers.[88] Normally, this standard is not familiar to laypersons and must be established at trial through expert testimony.[89] In relation to the knowledge aspect, this

87. Berman v. Allan, 80 N.J. 421, 432, 404 A.2d 8, 14 (1979).

88. *See* 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE 194-217 (1977); W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 32 at 165 (4th ed. 1971).

89. *E.g.*, Shea v. Phillips, 213 Ga. 269, 98 S.E.2d 552 (1957); Beane v. Perley, 99 N.H. 309, 109 A.2d 848 (1954).

means that the defendant practitioner is required to possess the learning and skill that are commonly possessed by members of the profession in good standing.[90] In relation to the communication aspect, the practitioner will be held to owe a duty to disclose to his client the information that a reasonable medical practitioner would disclose in similar circumstances.[91]

It is apparent that at the present time, judicial reliance on the professional standard in the area of genetic counseling will work in favor of defendant practitioners. At the present stage in the development of genetic counseling, plaintiffs are likely to have difficulty proving through expert testimony that a particular application of prenatal diagnosis is standard practice. In addition, plaintiffs in many jurisdictions may face the harsh consequences of the locality rule,[92] under which the defendant's responsibility is measured against the norms of practice in his or similar communities. This can pose a large obstacle to plaintiffs who live in small communities where genetic services are limited. If the plaintiff's complaint is that the practitioner did not disclose sufficient information in a way that the plaintiff could understand—a breach of the communication aspect of the standard—the plaintiff is certain to have a difficult time establishing the professional standard in this regard:

> [N]ot only do genetic counselors appear to lack tools to evaluate whether they are counseling properly and achieving the results that should be expected, but the very notion of "expectations" is rendered doubtful by the existence of diverse schools of thought, rather than a professional consensus on the right way to counsel.[93]

It is for these reasons that several commentators have suggested a different approach to setting the standard of care in the area of genetic counseling.[94] The suggested approach is to apply a standard analogous to the lay standard of the doctrine of informed consent, which has been applied in several recent medical malpractice cases.[95] Under this standard the relevant question is not "what other physicians typically do," but "what a reasonable patient would

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90. *See generally* 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE 194, 200–06 (1977). A classic formulation of this standard is found in Zoterell v. Repp, 187 Mich. 319, 330, 153 N.W. 692, 696 (1915) (physician must "bring and apply to the case in hand that degree of skill, care, knowledge, and attention ordinarily possessed and exercised by practitioners of the medical profession under like circumstances").

91. *E.g.*, Green v. Hussey, 127 Ill. App. 2d 174, 262 N.E.2d 156 (1970); Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960).

92. *E.g.*, Siirila v. Barrios, 58 Mich. App. 721, 228 N.W.2d 801 (1975). Some courts have held that community standards are only one factor to be considered in determining the issue of negligence. *E.g.*, Shier v. Freedman, 58 Wis. 2d 269, 206 N.W.2d 166 (1973). Other jurisdictions have disposed of the locality rule altogether, imposing a uniform standard of care on all physicians. *E.g.*, Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975).

93. Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 628–29 (1979).

94. *Id.* at 629–30; Note, *Father and Mother Know Best: Defining the Liability of Physicians for Inadequate Genetic Counseling*, 87 YALE L.J. 1488, 1507–08 (1978).

95. *See generally* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972).

want to know under the circumstances."[96] The standard focuses the analysis on the patient *qua* decision-maker, in recognition of her right to exercise control over her own medical care. The basic aim of the informed consent doctrine—to respect the patient's right to access of information—is particularly relevant to the communication aspect of the defendant's conduct, since it is concerned with the flow of information from the genetic counselor to his patient. One commentator has explained the application of the lay informed consent standard to genetic counseling in these words:

> Although doctors in the contexts of both informed consent and genetic counseling are not to make the ultimate choice among various courses of action, they possess information that [patients] often cannot otherwise easily obtain. Indeed, it is usually only through physician disclosure that prospective parents will be given the opportunity to act to avert the birth of children with genetic defects. Thus doctors should be required to inform prospective parents of all the genetic risks and reproductive options that a reasonable person would want to know in deciding whether to procreate.[97]

The adoption of the lay informed consent standard in genetic counseling would be philosophically consistent with the interest of parents that the *Becker* and *Berman* decisions purport to protect. It would also vitiate the problems facing a plaintiff trying to establish a fixed professional standard of disclosure when such a standard may not exist. Nevertheless, this Comment urges that the lay informed consent standard not be applied in cases involving negligent prenatal diagnosis. The adoption of this standard would inevitably force medical practitioners to respond to a market for genetic information that has essentially nothing to do with prevention of disease. Under *Roe v. Wade*,[98] a woman does not need to have a medical reason to obtain an abortion; her right to choose abortion is deemed to be unqualified, at least throughout the first two trimesters of pregnancy.[99] *A fortiori*, a woman can choose, in the absence of a compelling state interest to the contrary, to abort her child for any reason. Selective abortion for the purpose of avoiding an undesirable genetic characteristic and selective abortion for the purpose of producing a child with desirable genetic characteristics are simply two sides of the same coin. Without doubt, many parents would choose abortion for a variety of reasons other than prevention of a medically defined disorder. For example, parents could claim that their physician's negligent failure to advise them of the availability of amniocentesis or to disclose fully the laboratory

96. Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 629 (1979). *See* Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir), *cert. denied*, 409 U.S. 1064 (1972).

97. Note, *Father and Mother Know Best: Defining the Liability of Physicians for Inadequate Genetic Counseling*, 87 YALE L.J. 1488, 1507–08 (1978).

98. 410 U.S. 113 (1973).

99. *Roe v. Wade* is frequently interpreted to mean that the state may not prohibit abortions within the first three months of pregnancy. *E.g.*, Berman v. Allan, 80 N.J. 421, 431–32, 404 A.2d 8, 14 (1979). The decision's protection extends much further, however. Even in the last trimester, the *Roe* Court said the state could not prohibit abortion when necessary to preserve the health of the mother. "Health" in this context includes emotional health. Doe v. Bolton, 410 U.S. 179, 192 (1973). In effect, the right to abortion is nearly absolute throughout the entire period of gestation. *See* J. NOONAN, A PRIVATE CHOICE 10–12 (1979).

results of the procedure caused them to give birth to a child of the "wrong" sex. Under the lay informed consent standard, these parents would have only to convince a jury that the availability of amniocentesis to determine the sex of their fetus is information that a reasonable person would find relevant to reproductive decision-making.[100] They could at least recover damages for emotional distress under the *Berman* rule of damages,[101] and could theoretically recover the total costs of raising the child under the *Becker* rule of damages.[102] The result of imposing the lay informed consent standard in the field of prenatal diagnosis would be to coerce medical practitioners to participate in parents' pursuit of the perfect child, by placing those practitioners who decline such a role at risk of incurring civil liability. This result seems wrong, and for good reason. It is inappropriate from the viewpoint of both the medical profession, which has some valid claim to the right of determining the proper allocation of health care resources, and consumers, who ultimately share the costs of malpractice liability.

Precisely because of the potential for unusual and controversial applications of prenatal diagnosis, a finding of liability for negligence in this area should be predicated upon a deviation from a clearly recognizable standard of care, not the uncertain standard of "what a patient would want to know under the circumstances." The traditional professional standard should thus be applied by courts recognizing an action for the birth of a "defective" child. Any difficulty that a plaintiff may face in establishing the existence of professional norms in the area of prenatal diagnosis should support a finding of nonliability; it should not justify the adoption of a different, inappropriate standard merely to help plaintiffs with their case.

B. *Damages*

The overriding problem for the courts in parents' claims for wrongful birth has been the issue of damages. An attempt to fit compensation for the

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100. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir), *cert. denied*, 409 U.S. 1064 (1972) (materiality of the information withheld from the patient need not be established by expert testimony); Sard v. Hardy, 281 Md. 432, 379 A.2d 1014 (1977) (proper test for measuring the physician's duty to disclose risk information is whether such data is material to the patient's decision, to be decided by the jury). A claim by parents alleging the denial of the opportunity to avoid the birth of a child of the "wrong" sex will seem far-fetched only to those who have not kept abreast of the current trends in family planning. In one documented series of women offered amniocentesis and told the gender of their unborn children, twenty-nine (assumedly "reasonable") women out of forty-six who were informed that their children would be girls chose to abort. Of fifty-three women informed that their children would be boys, only one chose to abort. C. RICE, BEYOND ABORTION 98 (1979).

While scattered reports of this kind cannot be taken as scientific measurements of public attitudes, indications are that the use of prenatal diagnosis for selecting sex has so far been limited more by the unwillingness of physicians to provide this service, rather than a lack of demand on the part of prospective parents. *See* Letter to the Editor from A. Etzioni, 863 LANCET 932 (1974)(reporting results of a survey in which 95 percent of physicians questioned disapproved of using amniocentesis for gender selection). Recently, the Johns Hopkins hospital in Baltimore, Maryland, adopted a policy of performing amniocentesis for gender selection for any couple that requests it and undergoes counseling regarding the risks involved. Kazazian, *A Medical View*, in *Prenatal Diagnosis for Sex Choice*, 10 HASTINGS CENTER REP. 15, 17 (1980).

101. *See* text accompanying note 79 *supra*.

102. *See* text accompanying note 62 *supra*.

birth of an impaired child into the traditional framework of tort damages is at best precarious. One commentator has succinctly placed the problem in perspective:

> It is one thing to compensate destruction; it is quite another to compensate creation. This so-called "wrong" is unique: it is a new and on-going condition. As life, it necessarily interacts with other lives. Indeed, it draws its "injurious" nature from the predilections of the other lives it touches. It is naive to suggest that such a situation falls neatly into conventional tort principles, producing neatly calculable results.[103]

If the traditional rule of negligence law[104] were applied in wrongful birth cases to compensate the plaintiff for all injuries proximately caused by the defendant's negligence, the only limitation on recovery would lie in counsel's creativity. An inexhaustive list of possible items of recovery gleaned from previous wrongful birth cases might include: the costs of raising and educating the child;[105] lost wages;[106] medical and hospital costs related to delivery;[107] physical and emotional pain related to the pregnancy and delivery;[108] "physical inconvenience" of rearing an unwanted child;[109] and loss of consortium.[110] In addition, when the child is born with physical or mental disabilities, recovery might include the special costs relating to treatment and care, and damages for emotional distress caused by the birth. Concern over the prospect of staggering damage awards is apparent in the *Becker* and *Berman* decisions; both courts sought to limit damages by holding that certain items of injury are not compensable. Beyond this commonality, however, the cases cannot be reconciled. An elemental confusion of principles is evident in the fact that the two courts reached diametrically opposed conclusions about what items of injury should properly be compensated.

In Becker, parents sought damages for the cost of "the long-term institutional care of their retarded child," whom, the parents alleged, they would have aborted were it not for the defendants' negligence in failing to disclose the risk of genetic defect causing Down's syndrome.[111] The parents also sought damages for emotional harm caused by the birth of their child in an impaired condition.[112] The New York Court of Appeals upheld the claim for expenses incurred in the long-term institutional care of their child, but refused to permit recovery for emotional harm.[113] Concerning the claims for pecuniary expenses, the majority said: "Calculation of damages necessary to make

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103. Note, *Wrongful Birth Damages: Mandate and Mishandling By Judicial Fiat*, 13 VAL. L. REV. 127, 170 (1978).

104. C. MCCORMICK, DAMAGES § 137 at 560-61 (1935).

105. *E.g.*, Custodio v. Bauer, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967).

106. *E.g.*, Troppi v. Scarf, 31 Mich. App. 240, 187 N.W.2d 511 (1971).

107. *Id.*

108. *Id.*

109. *E.g.*, Betancourt v. Gaylor, 136 N.J. Super. 69, 344 A.2d 336 (1975).

110. *E.g.*, Sherlock v. Stillwater Clinic, 260 N.W.2d 169 (Minn. 1977).

111. 46 N.Y.2d 401, 406, 386 N.E.2d 807, 809, 413 N.Y.S.2d 895, 897 (1978).

112. *Id.*

113. *Id.* at 415, 386 N.E.2d at 814, 413 N.Y.S.2d at 902-03.

plaintiffs whole in relation to these expenditures requires nothing extraordinary."[114] The court equivocated, however, saying, "[t]here is now no occasion, in passing on the sufficiency of the complaints to state a cause of action, to determine with particularity what items of expense or loss may properly be taken into account in computation of the damages recoverable."[115] As the dissenting judge pointed out, the majority's analysis would seemingly entitle parents in other cases to recover all of the costs associated with raising an impaired child.[116] This measure of recovery is admittedly logical; in the absence of the physician's nondisclosure, the parents claim they would have avoided the birth of the child, and therefore would not have been burdened with any of the costs of raising the child.

The New Jersey Supreme Court in *Berman* also took as the basic measure of pecuniary damages the total costs of raising and caring for the child.[117] The *Berman* court disallowed recovery for pecuniary injury, however, citing three reasons.[118] First, recovery of such damages would be "wholly disproportionate" to the physician's culpability. Second, to allow this recovery would place too unreasonable a financial burden upon physicians. Finally, recovery would constitute a "windfall" for the parents, who would "retain all the benefits inhering in the birth of the child . . . while saddling defendants with the enormous expenses attendant upon her rearing."[119]

The first of these reasons advanced by the New Jersey court for denying compensation of pecuniary losses is not a rule of damages, but a liability-limiting policy consideration. As applied by the *Berman* court, however, the culpability argument is wholly unconvincing. In traditional tort law, a defendant will be found to have been either negligent or not negligent according to the applicable legal standard. If negligent, the defendant should be liable for all injury to the plaintiff's interests that the negligent conduct proximately caused. Aside from the recovery of punitive damages in certain cases, culpability should play no role in determining damages. The court's use of this criterion to limit recovery of certain items of injury while permitting recovery for others is strained to the point of being nonsensical.

The second argument of the New Jersey court—that recovery of pecuniary losses would place an unreasonable burden on physicians—must likewise be recognized as a make-weight argument. Assuming, *arguendo*, that the costs of raising and treating an impaired child constitute an injury to the plaintiffs' interests, the court offers no reason why placing this burden on the defendant is "unreasonable." These costs must devolve to someone; the

114. *Id.* at 413, 386 N.E.2d at 813, 413 N.Y.S.2d at 901.
115. *Id.*
116. *Id.* at 421–22, 386 N.E.2d at 818, 413 N.Y.S.2d at 906–07.
117. 80 N.J. 421, 432, 404 A.2d 8, 14 (1979).
118. *Id.*
119. *Id.*

defendant, who presumably carries insurance for such risks, is arguably in a much better position to bear them than the parents.

The third reason advanced by the court for denying recovery of pecuniary losses—that such recovery would be a windfall to the parents—is actually a restatement of the overriding benefits doctrine seen in some earlier wrongful birth cases.[120] The theory is that the intangible benefits conferred upon the parents—"the love and joy they will experience as parents"[121]—outweigh the pecuniary expenses incurred by the birth. The *Berman* court seriously weakened the force of its own analysis, however, by allowing recovery for emotional anguish. If the benefits inhering in the birth of the child are to be set off against the detriments, intangible emotional benefits should logically be compared to the emotional harm caused by the birth. This would be consistent with section 920 of the Restatement (Second) of Torts, which states:

> When the defendant's tortious conduct has caused harm to the plaintiff or to his property and in so doing has conferred a special benefit *to the interest of the plaintiff which was harmed*, the value of the benefit conferred is considered in mitigation of damages, to the extent that this is equitable.[122]

Striking out upon its own muddled course, however, the *Berman* court compared pecuniary damages with emotional benefits, and left emotional harm completely out of the balance. Firmly believing that "the monetary equivalent of [emotional] distress is an appropriate measure of the harm suffered by the parents deriving from Mrs. Berman's loss of her right to abort,"[123] the court disregarded logic and traditional rules of damages, passed over the tangible pecuniary elements of injury, and opted to allow recovery for the intangible, subjective, and purely speculative element of emotional distress.

The New York Court of Appeals in *Becker* followed a better reasoned approach to damages for emotional distress. The New York court correctly perceived that if parents claim emotional distress caused by the birth of the child, damages for that distress must, in fairness, be mitigated by the intangible benefits inherent in the parent-child relationship.[124] The court then held that any comparison for this purpose is simply too speculative to permit recovery.[125]

This Comment proposes that, if parents are recognized to have a cause of action in tort for the birth of a "defective" child, damages should be limited to the pecuniary expenses relating to the special care required by the child which exceed the normal expenses associated with raising a healthy child. This measure of damages, although not accepted by either the New York Court of

120. *See* text accompanying notes 37–38 *supra*.
121. Berman v. Allan, 80 N.J. 421, 432, 404 A.2d 8, 14 (1979).
122. RESTATEMENT (SECOND) OF TORTS § 920 (1979) (emphasis added).
123. 80 N.J. 421, 433, 404 A.2d 8, 14 (1979).
124. Becker v. Schwartz, 46 N.Y.2d 401, 414–15, 386 N.E.2d 807, 814, 413 N.Y.S.2d 895, 902 (1978).
125. *Id.* at 415, 386 N.E.2d at 814, 413 N.Y.S.2d at 902 (1978).

Appeals or the New Jersey Supreme Court, does have some judicial support.[126]

Recovery of pecuniary costs should be limited to the costs directly related to the child's impairment, not the total costs of raising the child. It is not necessary, in order to justify this measure of recovery, to adopt the fiction that the parents would have given birth to a normal, healthy child in the absence of the defendant's negligence. It can be justified simply by looking to the specific financial interest of the plaintiffs that was injured.[127] Unlike the plaintiffs in the "healthy but unwanted" child wrongful birth cases, the parents in *Becker* and *Berman* desired to have a child. They did not engage the defendants' services for the purpose of preventing reproduction, but for furthering the normal process of pregnancy. It is fair to presume that they were ready and willing to assume the financial burdens normally associated with raising a child. The specific interest that they allege has been injured is not the broad "right to abort,"[128] as the New Jersey Supreme Court would have it; rather, the gravamen of the complaint is that they were denied the opportunity to avoid the birth of this specific child with its specific "defect." Thus, to the extent that public policy permits any recovery at all,[129] it is both logical and just to restrict recovery of economic damages to the costs relating to the "defect." Such costs may include special medical, nursing, custodial, and educational expenses that the parents would not have incurred by the birth of a healthy child.

Plaintiffs should also be precluded from recovering damages for items such as physical pain and suffering related to childbirth, loss of income, loss of consortium, and lost opportunities, except to the extent that plaintiffs can prove that any of these are related to the child's impairment, since each detriment would have been experienced with the birth of a healthy child anyway.

The approach of the New York of Appeals in *Becker* in denying damages for emotional distress should be recognized as sound. A fundamental principle of damages requires the plaintiff to prove facts upon which the trier of fact can base a just and reasonable valuation of damage.[130] This would require the plaintiffs to prove that they suffered emotional harm by the birth of their child that they would not have suffered had the child's life been terminated *in*

126. *See* Jacobs v. Theimer, 519 S.W.2d 846 (Tex. 1975)(recovery for parents of a child with rubella-related deformities limited to the special costs relating to care and treatment); Dumer v. St. Michael's Hosp., 69 Wis. 2d 766, 233 N.W.2d 372 (1975) (same).

127. *See* Christensen v. Thornby, 192 Minn. 123, 255 N.W. 620 (1934). In *Christensen*, the first recorded case involving a wrongful birth claim, the Minnesota Supreme Court denied recovery to parents of a healthy child after an unsuccessful sterilization on the ground that plaintiffs' interest had not been injured. Evidence at trial showed that the operation had been sought not to prevent the expenses of child-raising, but to avoid endangering the mother's precarious health; ultimately the mother's health was not harmed by the birth. *Cf.* RESTATEMENT (SECOND) OF TORTS § 281, comment g (1965).

128. Berman v. Allan, 80 N.J. 421, 432, 404 A.2d 8, 14 (1979).

129. *See* text accompanying notes 155–160 *infra*.

130. *See* D. DOBBS, REMEDIES § 3.3 (1973).

utero. The jury would be required to place a value upon a subjective state that the plaintiffs did not actually experience. Any valuation in dollars and cents of the parents' emotional damage would be based not on fact, but upon pure speculation. And, if the emotional benefits conferred by the child are offset against the damage in mitigation, the speculation is compounded. Claims of this nature should not be recognized.

The limitations on damages for the birth of a "defective" child that this Comment proposes would have several beneficial effects. Since potential plaintiffs would know that they could not recover the total costs of raising their child, parents would be inhibited from asserting fraudulent claims in the hope of winning a huge recovery. Strictly limiting recovery to those pecuniary expenses related to the child's condition would, to some extent, diminish the undesirable social effect that will inevitably result from this type of litigation—the placing of a price tag on human life based on its perceived quality—and affirm our fundamental belief that the responsibility to raise and care for children belongs primarily to their natural parents.[131] Finally, limited recovery ought to satisfy those who conceive the law of negligence as a force to deter future negligent conduct.[132]

V. LIABILITY FOR THE BIRTH OF A DEFECTIVE CHILD: DEFECTIVE JUDICIAL LEGISLATING?

A cause of action imposing liability for the birth of a genetically impaired child is a new tort, unknown at common law. Indeed, this type of litigation could never have come into existence without the abrupt and relatively recent changes that have occurred in the law and the technology relating to human reproduction. Science has developed the means of discovering human genetic traits *in utero*, allowing parents to know many characteristics of their children before the children are born. The United States Supreme Court has made abortion the right of every woman, allowing parents to act on the information gained through technology.[133] Now, the *Becker* and *Berman* decisions indicate that the courts are willing to make this application of technology a legally protected interest, by imposing liability when the technology is wrongfully withheld.

At the same time, the *Becker* and *Berman* decisions unfortunately indicate a failure by the courts to give adequate consideration to the serious social implications of imposing this liability. A cause of action arising from the birth of a "defective" child involves delicate questions of professional responsibility, the valuation of human life based upon its perceived quality, and the

131. *See, e.g.*, Massey v. Flinn, 198 Ark. 279, 128 S.W.2d 1008 (1939) (father may not contract away his obligation to financially support his child).

132. "[To deny recovery] would in effect immunize from liability those in the medical field providing inadequate guidance to persons who would choose to exercise their constitutional right to abort fetuses . . . ." Berman v. Allan, 80 N.J. 421, 432, 404 A.2d 8, 14 (1979).

133. Roe v. Wade, 410 U.S. 113 (1973).

sensitive moral and policy issues of eugenic abortion. The judicial activism in recognizing this new cause of action has demonstrated a woeful disregard for these issues.

A. *Malpractice and the Technological Imperative*

In describing how the courts assimilate new technological developments in the field of human genetics, it has been said that judge-made law is "essentially backwards-looking"[134]—that is, it strives to compensate persons who have already suffered some injury, and not to prescribe how medical science should control the use of technology in the future. Yet, it cannot be seriously doubted that court decisions creating liability for the birth of a genetically impaired child are potently forceful in shaping professional standards of conduct. Most physicians, reacting to exorbitant malpractice insurance rates and the threat of personal liability, believe that they "must practice defensively, and do so."[135] After the *Becker* decision, it was predicted that amniocentesis would be employed in all pregnancies "on legal grounds, not medical grounds."[136] Some physicians report that they use amniocentesis on women below 35 years of age even though such women are not subject to an elevated risk of bearing a child with a chromosomal anomaly. A major factor in promoting such practices, they acknowledge, is fear of liability.[137]

At the heart of this progression—increased use of technology in response to court-created liability—lies an internal inconsistency that the courts and commentators have not addressed. While courts are analysing medical practitioner's conduct according to professional standards, the legal interest of the parent-plaintiffs that the courts are purporting to protect has nothing to do with medicine, except in a most Pickwickian sense. The decision to abort a fetus afflicted with Down's syndrome is not a medical decision, but a personal, ethical, and social decision. Although it is true that a medical professional's expert knowledge and cooperation are required if parents are to exercise the choice to abort, it does not follow that this use of technology is simply a matter of professional standards. A far more basic question to be asked, but scarcely reached by the *Becker* and *Berman* opinions, is what policy reasons justify the imposition of an affirmative legal duty to employ prenatal diagnosis.

If court decisions establish prenatal diagnosis of genetic disorders as a duty owed to all parents at risk of bearing a genetically impaired child, a long, albeit unconscious, step will have been taken in the direction of removing this application of technology from the realm of personal decision-making and

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134. Green, *The Fetus and the Law*, in GENETICS AND THE LAW 19, 24 (A. Milunsky & G. Annas eds. 1976).

135. Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 667 n.206 (1979).

136. *Doctors Held Liable in Abnormal Births*, N.Y. Times, Dec. 28, 1978, at B6, col. 4.

137. Powledge, *Prenatal Diagnosis: New Techniques, New Questions*, 9 HASTINGS CENTER REP. 16 (1979).

transferring it into the class of judgments known as "medical indications." This subtle change in professional and public awareness will have far-reaching implications. Social pressures may well inhibit, rather than reinforce, autonomous decision-making by parents who would choose to give birth to a child with substantial impairments.[138] There have already been suggestions that medical insurers might refuse to provide coverage to women who refuse to undergo amniocentesis and abort an abnormal fetus.[139]

Of course, there is a very real possiblity that our health care systems will arrive at the same point in establishing norms for the use of prenatal diagnostic technology without prodding by the courts. It seems far preferable, however, to allow this standard-setting process, entailing as it does such serious implications for society, to evolve naturally in response to broad-based social needs and public policy as expressed by legislative action, rather than in reaction to the fear of malpractice liability.

B. *"Defectiveness"—A New Determinator of Legal Rights?*

Another cause for concern with the judicial recognition of a cause of action for the birth of a genetically impaired child is the apparent willingness of courts to decide cases on little more than the judges' personal perception of the value of the "defective" life in question. Of course, courts are called upon every day to make subjective judgments in critical matters; yet, it is important to recognize this judicial decision-making function in wrongful birth cases so that a critical examination can be focused on the underlying basis of these decisions.

An example of judicial subjectivity is evidenced by two wrongful birth decisions of the Wisconsin Supreme Court. In 1974, the court ruled in *Rieck v. Medical Protective Co.*[140] that parents who gave birth to a healthy child had no cause of action against a physician who negligently failed to diagnose the woman's pregnancy in time for her to procure a legal abortion. The court cited two policy reasons for denying recovery, either of which, the court said, alone would have been sufficient basis for denial of recovery.[141] One year later, in *Dumer v. St. Michael's Hospital,*[142] the same court was faced with the claim of parents who sought wrongful birth damages against a physician who failed to diagnose rubella during the woman's pregnancy; she gave birth to a child with deformities caused by the infection. Here, without disturbing the *Rieck* decision, the court allowed recovery.[143] The compelling policy reasons against

138. Callahan, *The Meaning and Significance of Genetic Disease: Philosophical Perspectives,* in ETHICAL ISSUES IN HUMAN GENETICS 83, 85 (B. Hilton *et al.* eds. 1973).

139. *See* Thompson & Greenfield, *Rights and Responsibilities of the Insurer,* in GENETICS AND THE LAW 289 (A. Milunsky & G. Annas eds. 1976).

140. 64 Wis. 2d 514, 219 N.W.2d 242 (1974).

141. To allow recovery, said the court, would open the way for fraudulent claims and would place too unreasonable a burden upon physicians. *Id.* at 518–19, 219 N.W.2d at 244–45.

142. 69 Wis. 2d 766, 233 N.W.2d 372 (1975).

143. *Id.*

recognizing a cause of action for the unwanted birth of a healthy child had suddenly vanished in the case of a deformed child.

Following the advice of Llewellyn to look not to what the Wisconsin court *said*, but to what it *did*,[144] it is obvious that the court created a legal classification affecting important legal rights based purely upon the court's perception of the *quality* of the human life under consideration. In *Rieck*, the parents did not want a child, normal or abnormal. In *Dumer*, the parents wanted a child but not an abnormal child. In each case, the child had already been conceived and the alleged negligence of the physician was in failing to diagnose a condition that would have led the woman to get an abortion. In the view of the Wisconsin Supreme Court, the birth of a normal, healthy child is not a compensable injury as a matter of law, but the birth of a deformed child is.

It is possible to see in this development an understandable judicial response to perceived tragedy. No doubt the Wisconsin court in *Dumer* felt a particular sympathy for the parents of the impaired child. The New Jersey Supreme Court probably felt a similar sympathy for the Bermans, when it said, citing no precedent, "We *feel* that the monetary equivalent of [the Bermans' emotional anguish] is an appropriate measure of the harm suffered . . . ."[145] It is appropriate, however, to question whether this subjective and arbitrary manner of decision-making is a proper foundation for legal precedent. If cases were decided on an *ad hoc* basis, there might be small cause for concern; but our system of judicial lawmaking is one in which individual decisions have much broader repercussions. If the underlying principle is that compensation depends upon defectiveness, it is not difficult to imagine the problematic aspects of applying such a principle. "Defective" and "normal" are impossible to define. In the context of genetic health, how far from "normal" must a child's genotype or phenotype deviate to permit recovery? It is estimated that every human carries from five to eight "bad" genes.[146]

Once the principle is established that the parents' rights are dependent on their child's genetic status, it is not reaching beyond the bounds of reasonable prognostication to see an analogous principle being applied to the rights of impaired children born to society. This has already been done by a California juvenile court. In the case of *In re Phillip B.*, [147] court consent for life-saving surgery was withheld from an eleven-year-old boy with Down's syndrome, apparently for no other reason than to respect the parents' desire that the child not outlive them.[148] The trial judge, in explaining his order from the

144. K. LLEWELLYN, THE BRAMBLE BUSH 14 (1930).

145. Berman v. Allan, 80 N.J. 421, 433, 404 A.2d 8, 14 (1979) (emphasis added).

146. NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES, WHAT ARE THE FACTS ABOUT GENETIC DISEASE? 6 (1975).

147. *In re* Phillip B., 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979).

148. Annas, *The Case of Phillip Becker: A Legal Travesty*, 1 NURSING LAW & ETHICS 4, 4 (1980). The author of the cited article says this decision is based on "eugenic policy," "devalues human life in the name of family autonomy," and treats the mentally retarded "little better than household pets." *Id.* at 4, 6.

bench, dwelt at some length upon the emotional difficulties facing parents of a genetically handicapped child.[149] This brings to mind the words of a leading American bioethicist: "[I]t will be the soft-hearted rather than the hard-hearted judges who will establish the doctrine of second class human beings . . . ."[150]

C. *Eugenic Abortion and Public Policy*

In *Gleitman v. Cosgrove*,[151] parents sought to recover wrongful birth damages for having been denied the opportunity to abort their congenitally abnormal child. The New Jersey Supreme Court denied recovery, finding that there was a public policy in New Jersey of protecting prenatal life which outweighed the parents' interest in terminating that life.

> We are not talking here about the breeding of prize cattle. It may have been easier for the mother and less expensive for the father to have terminated the life of their child while he was an embryo, but these alleged detriments cannot stand against the preciousness of the single human life to support a remedy in tort. . . . We hold, therefore, that the [claims of the parents] are not actionable because the conduct complained of, even if true, does not give rise to damages cognizable at law; and even if such alleged damages were cognizable, a claim for them would be precluded by the countervailing public policy supporting the preciousness of human life.[152]

Eleven years later, the same court concluded in *Berman v. Allan*[153] that "[p]ublic policy now supports, rather than militates against, the proposition that [a mother] not be impermissibly denied a meaningful opportunity to make [the] decision [to abort her defective child]."[154]

The *Berman* court cited no state legislation or legislative history, nor discussed any social or economic changes to which it could attribute its abandonment of the public policy "supporting the preciousness of human life." What the court did cite was Mrs. Berman's constitutional right to choose abortion,[155] established by the United States Supreme Court in *Roe v. Wade*.[156] Apparently, the court reasoned that the constitutional right to abortion mandated a public policy of providing compensation when a woman is denied the meaningful opportunity to decide to abort. That conclusion, however, is completely unfounded. While *Roe v. Wade* did establish that a state may not interfere with a woman's right to choose abortion, it did not establish that every woman has a right to receive any information that might be meaningful to her in making the abortion decision. Whatever public policy *Roe* may

149. *Id.* at 6.

150. Kass, *Implications of Prenatal Diagnosis for the Human Right to Life*, in BIOMEDICAL ETHICS AND THE LAW 313, 318 (M. Humber & R. Almeder eds. 1976).

151. 49 N.J. 22, 227 A.2d 689 (1967).

152. *Id.* at 30–31, 227 A.2d at 693.

153. 80 N.J. 421, 404 A.2d 8 (1979).

154. *Id.* at 432, 404 A.2d at 14.

155. *Id.* at 431, 404 A.2d at 14.

156. 410 U.S. 113 (1974).

impose, it scarcely reaches as far as the *Berman* court supposed. Indeed, more recent Supreme Court decisions[157] show that states are not prevented from pursuing a policy of protecting prenatal life as long as state action does not directly impinge on the woman's right to choose abortion. In *Maher v. Roe*[158] the Court said, "There is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy."[159] Moreover, the Court has taken several opportunities to reaffirm that a state's interest in protecting prenatal life is "time-honored," "important," even "vital."[160]

A reasonable interpretation of these cases would indicate that New Jersey could, consonant with a policy of affirming the public mores concerning the value of prenatal life, deny recovery in civil actions based upon a diminished "meaningful opportunity" to abort, since the denial of recovery would in no way interfere with or discourage a constitutionally protected right. If the New Jersey Supreme Court had wished to look to sources of public policy within the state, it needed to look no farther than to the state legislature, which in 1975 passed a resolution calling for a constitutional amendment that would protect the fetus's right to life from the moment of conception. Instead, the court bypassed this clear proclamation of public policy from the state's own legislative body, and erroneously concluded that *Roe v. Wade* had set the only applicable policy on abortion for New Jersey. This cavalier treatment of sensitive policy issues provides one more reason why the recognition of a cause of action for the birth of a genetically impaired child should be left to the legislature. Only a legislative body can give the policy issues involved the full and fair discussion that they deserve.[161]

VI. CONCLUSION

The issues presented in *Becker* and *Berman* are only the first of the many vexing questions that will be posed in our legal forums as prenatal diagnosis and genetic counseling become more common practices. This Comment has attempted to show that the theory of liability for negligent prenatal diagnosis contains new and unsettled issues, although it superficially shares similarities with previous wrongful birth decisions. The problematic aspects of this cause of action are apparent in that two courts considering identical allegations reached diametrically opposite conclusions about what compensable injury the plaintiff-parents suffered by the birth. This Comment advances two sug-

157. *See* Harris v. McRae, 100 S. Ct. 2671 (1980); Maher v. Roe, 432 U.S. 464 (1977); Poelker v. Doe, 432 U.S. 519 (1977).

158. 432 U.S. 464 (1977).

159. *Id.* at 475.

160. Harris v. McRae, 100 S. Ct. 2671, 2686–88 (1980); Poelker v. Doe, 432 U.S. 519, 525 (1977); Maher v. Roe, 432 U.S. 464, 471 (1977).

161. "[W]hen an issue involves policy choices as sensitive as those implicated [in abortion funding] . . . , the appropriate forum for their resolution in a democracy is the legislature." Maher v. Roe, 432 U.S. 464, 479 (1977).

gestions for deriving just limits to the medical practitioner's liability when his conduct leads to the birth of a genetically impaired child. First, if courts recognize the cause of action at all, they should reject arguments that a lay informed consent standard of care is appropriate in the context of prenatal diagnosis. This standard would force practitioners to participate in parents' pursuit of the perfect child to an unacceptable degree. The traditional malpractice standard of care is more appropriate, since liability should be predicated upon a clear deviation from professionally accepted standards, and not a conflict with the patient's personal predilections. Second, damages should be limited to the tangible pecuniary expenses that the parents incur for the special care of their child relating to the child's impairment. Any other measure of damages would either exceed the true injury to the parents' legitimate interests or be too speculative to permit a just determination. Finally, the Comment urges that the recognition of this cause of action involves important policy issues that courts cannot adequately treat through the judicial process.

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